Department of Veterans Affairs

COMMUNITY CARE PROVIDER - MEDICAL REQUEST FOR SERVICE

(Separate Form Required for Each Service Requested)

Request for Service (RFS) Submission Requirements: Complete the Medical or DME RFS form for services not on the original authorization or to request a new authorization for services. Only one request per form. (1) Complete RFS form 10-10172. (2) Attach appropriate medical records and care plan to support the request. (3) Have the ordering provider sign and date the form. (4) Submit request via HSRM, Fax, or Secure E-mail.

NOTE: Requests are approved/denied at the VA facility's discretion and supporting documentation must accompany each request.

SECTION I: VETERAN & ORDERING PROVIDER INFORMATION

1. VETERAN'S LEGAL FULL NAME *(First, MI, Last)*:	2. DATE OF BIRTH *(MM/DD/YYYY)*:
3. VA FACILITY & ADDRESS:	4. VA AUTHORIZATION NUMBER:
5. ORDERING PROVIDER OFFICE NAME & ADDRESS:	6. INDIAN HEALTH SERVICES *(IHS)* PROVIDER/ TRIBAL HEALTH PROGRAM *(THP)*? ☐ NO ☐ YES

7. ORDERING PROVIDER PHONE NUMBER *((999) 999-9999)*:	8. ORDERING PROVIDER FAX NUMBER *((999) 999-9999)*:	9. ORDERING PROVIDER SECURE EMAIL ADDRESS:

SECTION II: TYPE OF CARE REQUEST

10. IS CARE NEEDED WITHIN 48 HOURS? *(Based on the clinical need of the patient)* ☐ NO ☐ YES *(Note: If care is needed within 48 hours, please contact your VA facility directly)* *(Risk of Suicide/Homicide, call VA directly and submit RFS form)*	11. IS THIS A CONTINUATION OF CARE? ☐ NO ☐ YES

12. IS THIS A REFERRAL TO ANOTHER SPECIALTY?
☐ NO ☐ YES, SPECIALTY: _____

13. DIAGNOSIS CODES *(ICD-10)*:	14. DIAGNOSIS DESCRIPTION:	15. REQUESTED CPT/HCPCS CODE:	16. DESCRIPTION CPT/HCPCS CODE

17. GERIATRIC AND EXTENDED CARE *(Note: Add needed details to the justification section)*:
☐ COMMUNITY NURSING HOME ☐ HOME INFUSION ☐ HOSPICE/PALLIATIVE CARE ☐ SKILLED HOME HEALTH CARE
☐ COMMUNITY ADULT DAY HEALTH CARE ☐ HOME HOMEMAKER/HOME HEALTH AIDE ☐ RESPITE

18. REASON FOR REQUEST *(To avoid delays in care, include appropriate documentation such as office notes, current treatment plans, clinical history, laboratory results, radiology results &/or medications to support the medical necessity of services requested)*:

ATTESTATION: I do hereby attest that the forgoing information is true, accurate, & complete to the best of my knowledge & I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. I do hereby acknowledge that VA reserves the right to perform the requested service(s) if the following criteria are met: (1) The patient agrees to receive services from VA (2) Service(s) are available at VA facility & are able to be provided by the clinically indicated date (3) It is determined to be within the patient's best interest. Upon completion of the requested service(s), VA will provide all resulting medical documentation to the ordering provider. If all criteria listed are not true & VA agrees the service(s) are clinically indicated, VA will provide a referral for services to be performed in the community. I do hereby attest that upon receipt of order/consult results, I will assume responsibility for reviewing said results, addressing significant findings, & providing continued care.

19. ORDERING PROVIDER NAME *(PRINTED)*:	**20. ORDERING PROVIDER NPI#:**
21. ORDERING PROVIDER SIGNATURE *(Required)*:	**22. TODAY'S DATE *(MM/DD/YYYY)*:**

For more information please visit: https://www.va.gov/COMMUNITYCARE/providers/Care-Coordination.asp.

For additional contact information, please visit: https://www.va.gov/COMMUNITYCARE/providers/Care-Coordination-Facilities.asp.

Additional Resource: Clinical Determinations and Indications. VA Clinical Determinations and Indications (medical policies) describe standard VA health care benefits for services and procedures that community providers may recommend as necessary for a Veteran. Prior to providing care, providers should use Clinical Determinations and Indications (CDIs) as a reference when determining if a Veteran meets VA clinical criteria. When additional services are requested, Clinical Determinations and Indications will be used to determine approval by a clinical reviewer. Clinical Determinations and Indications, as well as supporting information, can be found at: https://www.va.gov/COMMUNITYCARE/providers/info-CDI.asp.

Department of Veterans Affairs

COMMUNITY CARE PROVIDER - DURABLE MEDICAL EQUIPMENT/PROSTHETICS REQUEST FOR SERVICE

(Separate Form Required for Each Service Requested)

Request for Service (RFS) Submission Requirements: Complete the Medical or DME RFS form for services not on the original authorization or to request a new authorization for services. Only one request per form. (1) Complete RFS form 10-10172. (2) Attach appropriate medical records and care plan to support the request. (3) Have the ordering provider sign and date the form. (4) Submit request via HSRM, Fax, or Secure E-mail.

NOTE: Failure to thoroughly complete the RFS for DME will result in delayed patient care and prevent the VA from DME fulfillment.

SECTION I: VETERAN & ORDERING PROVIDER INFORMATION

1. VETERAN'S LEGAL FULL NAME *(First, MI, Last)*:	2. DOB *(MM/DD/YYYY)*:
3. VA FACILITY & ADDRESS:	4. VA AUTHORIZATION NUMBER:
5. ORDERING PROVIDER OFFICE NAME & ADDRESS:	6. INDIAN HEALTH SERVICES *(IHS)* PROVIDER/ TRIBAL HEALTH PROGRAM *(THP)*? ☐ NO ☐ YES

7. PHONE NUMBER *((999) 999-9999)*:	8. FAX NUMBER *((999) 999-9999)*:	9. SECURE EMAIL ADDRESS:

SECTION II: HOME OXYGEN REQUEST

10. PA02 AT REST:	11. O2 SAT AT REST:	12. OXYGEN FLOW RATE:
13. EXTENT OF SUPPORT *(Continuous, Intermittent, Specific Activity)*:	14. OXYGEN EQUIPMENT *(Stationary/Portable)*:	15. DELIVERY SYSTEM *(Cannula, Mask, Other)*:

SECTION III: DME & PROSTHETICS REQUEST

Please see https://www.va.gov/COMMUNITYCARE/providers/DME-Requirements.asp for URGENT DME requests.

16. HCPCS CODE(S) FOR ITEM(S) BEING PRESCRIBED:	17. BRAND, MAKE, MODEL, PART NUMBERS:	18. MEASUREMENTS:
19. QUANTITY:	20. ICD-10:	21. PROVISIONAL DIAGNOSIS:

22. EDUCATION, TRAINING, &/OR FITTING OF DME MUST BE PROVIDED TO THE VETERAN. HAS THE FOLLOWING BEEN COMPLETED:

A. EDUCATION: ☐ NO ☐ YES

B. TRAINING: ☐ NO ☐ YES ☐ N/A

C. FITTING: ☐ NO ☐ YES ☐ N/A

23. DELIVERY PREFERENCE *(If incomplete, DME will be mailed to requesting provider)*:

☐ DELIVER TO ORDERING PROVIDER'S ADDRESS

☐ VETERAN WILL PICKUP AT THE VA FACILITY

☐ DELIVER TO COMMUNITY VENDOR FOR DELIVERY & SETUP OF DME

☐ DELIVER TO VETERAN'S HOME

SECTION IV: THERAPEUTIC FOOTWEAR ASSESSMENT INFORMATION

☐ LEFT FOOT ☐ RIGHT FOOT ☐ BILATERAL ☐ PREFABRICATED THERAPEUTIC FOOTWEAR ☐ CUSTOM THERAPEUTIC FOOTWEAR

24. CHECK APPROPRIATE DIABETIC/AMPUTATION RISK SCORE *(Only patients with medical conditions below can be prescribed therapeutic/diabetic footwear)*:

☐ **RISK SCORE 2:** Patient demonstrated sensory loss (inability to perceive the Semmes-Weinstein 5.07 monofilament), diminished circulation as evidenced by absent or weakly palpable pulses, foot deformity, or minor foot infection, & a diagnosis of diabetes.

☐ **RISK SCORE 3:** Patient demonstrated peripheral neuropathy with sensory loss *(i.e., inability to perceive the Semmes-Weinstein 5.07 monofilament)*, and diminished circulation, and foot deformity, or minor foot infection & a diagnosis of diabetes, or any of the following by itself: (1) prior ulcer, osteomyelitis or history of prior amputation; (2) severe peripheral vascular disease *(PVD) (intermittent claudication, dependent rubor with pallor on elevation, or critical limb ischemia manifested by rest pain, ulceration, or gangrene)*; (3) Charcot's joint disease with foot deformity; & (4) end stage renal disease.

25. DESCRIBE FOOT DEFORMITY AND DETAILS *(Requires severe or gross foot deformity which cannot be accommodated with conventional footwear)*:

26. REASON FOR REQUEST *(To avoid delays in care, include appropriate documentation such as office notes, current treatment plans, clinical history, laboratory results, radiology results &/or medications to support the medical necessity of services requested)*:

ATTESTATION: I do hereby attest that the forgoing information is true, accurate, & complete to the best of my knowledge & I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. I do hereby acknowledge that VA reserves the right to perform the requested service(s) if the following criteria are met: (1) The patient agrees to receive services from VA (2) Service(s) are available at VA facility & are able to be provided by the clinically indicated date (3) It is determined to be within the patient's best interest. Upon completion of the requested service(s), VA will provide all resulting medical documentation to the ordering provider. If all criteria listed are not true & VA agrees the service(s) are clinically indicated, VA will provide a referral for services to be performed in the community. I do hereby attest that upon receipt of order/consult results, I will assume responsibility for reviewing said results, addressing significant findings, & providing continued care.

27. ORDERING PROVIDER NAME *(PRINTED)*:	**28. ORDERING PROVIDER NPI#:**
29. ORDERING PROVIDER SIGNATURE *(Required)*:	**30. TODAY'S DATE *(MM/DD/YYYY)*:**